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AUTHOR Hatfield, Maryellen Brown
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ABSTRACT

Consistent with the first of the National Educational Goals 1990 (to ensure that all children in America will start school ready to learn by the year 2000), South Carolina initiated the Pre-School Health Appraisal Project (PSHAP), a collaborative practice model based on the experiences of 4 years of project development and findings. Initiated in 1988 and funded by the state, the project was tasked with providing pre-school comprehensive health appraisals for children prior to their entrance into first grade. Appraisals were conducted by public health nurses, nurse practitioners, and school nurses at the school site. The service was offered to all children at no cost; parents were encouraged to be present; conditions and problems were identified; referrals were made to the private sector; payment sources for care included Medicaid, self-pay, and health insurance; referral outcomes were monitored; and parents were educated to care for minor health conditions in their children. Data tables and charts are included in the paper. Appendices, which comprise about three-quarters of the paper, provide PSHAP forms, home treatment letters, information on school and health district responsibilities, confidential parent questionnaire, coordinators' instructions, maps of school districts eligible for PSHAP, and a list of selected PSHAP participating school districts in PSHAP year 4. (LL)

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HEALTH ASSESSMENT

AND

READINESS TO LEARN:

AN INTERAGENCY COLLABORATIVE MODEL

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PRESENTED:

AMERICAN SCHOOL HEALTH ASSN.
THE 66TH ANNUAL CONFERENCE
ORLANDO FLORIDA
OCTOBER 11, 1992

SUBMITTED BY:

MARYELLEN BROWN HATFIELD
NURSE CONSULTANT, SCHOOL HEALTH
DIVISION OF CHILDREN'S HEALTH
SOUTH CAROLINA DEPARTMENT OF
HEALTH AND ENVIRONMENTAL CONTROL
ROBERT MILLS COMPLEX -- JARRETT BLDG
BOX 101106
COLUMBIA, SOUTH CAROLINA 29211

SP034525

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- South Carolina School Districts Eligible for PSHAP
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PRESENTATION
AT THE
AMERICAN SCHOOL HEALTH ASSOCIATION

"HEALTH ASSESSMENT AND READINESS TO LEARN:
AN INTERAGENCY COLLABORATIVE MODEL"

SUNDAY, OCTOBER 11, 1992
9:45 A.M. -- 10:45 A.M.

INTRODUCTION:

In 1990 the President and governors of the United States agreed upon and developed a plan with six major education goals for the nation's schools to achieve. The purpose of the plan is to help improve the quality of education by setting high standards and by focusing attention on how well our society is able to achieve them. The first goal identified is:

> To ensure that all children in America will start school ready to learn by the Year 2000.

The basic premise behind this goal is that a solid foundation during the pre-school years will enhance prospects for later school success.

Objectives set to reach this goal (Overhead # 1) are:

1. "All disadvantaged and disabled children will have access to high quality and developmentally appropriate preschool programs that help prepare children for school."

2. "Every parent in America will be a child's first teacher and devote time each day helping his or her preschool child learn; parents will have access to the training and support they need."

3. "Children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, and the number of low birth weight babies will be significantly reduced through enhanced prenatal health systems."

These goals have significance for public health and human service providers as well. Surgeon General Dr. Antonia Novello identifies health as an integral component of both education objectives and the related national health promotion and disease prevention objectives. Noting that the healthy children ready to learn goal starts with the underlying concept that health is

a critical partner to optimum education, she challenges us to assure the optimum use of available and effective preventive measures, such as ensuring compliance with immunization recommendations; promoting measures to prevent injuries; ensuring opportunities to identify disease and disabilities early; and providing prompt treatment when needed. Dr. Novello calls on professional organizations and other private sector groups involved with health, education and other children's issues to work with government and families to achieve the school readiness goal and its related health objectives.

The following are health objectives that relate to school readiness: (Overhead # 2)

1. Maternal health and prenatal care	8. Reducing environmental problems
2. Immunization	9. Oral health
3. Access to quality preschool programs	10. Asthma
4. Adequate nutrition	11. Screening for impairment of vision & hearing
5. Violence and child abuse	12. Speech/language, developmental milestones and chronic disease
6. Injury prevention	
7. Reducing mental retardation	13. Financing preventive services

School nurses have long been proponents of the message that "healthy children learn better" (Overhead # 3) and should be very pleased at the direction set by the federal government.

While there are many dimensions to "readiness," the first of these is physical well-being, one component of which is the early identification of health problems that may not be identified by parents, or not deemed as significant, especially in families who have not had access to or not been consumers of preventive well- child health care.

As school nurses we have a major interest and in seeing that the school readiness goal is met and that children begin school healthy. We have the opportunity to endorse this concept and promote this now official message in our school setting. As school nurses you are still most often the only health professional in your school setting, but you now have the credibility of our government supporting the importance of health as a component of successful schooling. I want to set the stage for this presentation by being sure that you are fully aware of this initiative and its importance to school health programs.

This presentation will be based on the South Carolina Pre-School Health Appraisal Project, a collaborative practice model based on the experiences of four years of project development and findings, including the expanded health awareness and impact on the community. We hope that our findings will help you to:

-- assess the need for health appraisals as a component of readiness for school entry in assigned schools

and be able to:

-- describe a working model of interagency collaboration targeting low socio-economic medically underserved children.

and

-- identify opportunities in school nursing practice that can enhance community awareness of the importance of health as a component of academic success.

and

-- identify outcome-oriented goals for school health nursing to incorporate in your nursing practice.

The Pre-School Health Appraisal Project was first initiated in the 1988-89 school year. The project was supported with a special state appropriation, through a proviso attached to the state Department of Education budget bill. The funding was to be transferred to the Department of Health & Environmental Control, with instructions to pilot a project that would provide pre-school health appraisals in school districts with more than 50% of their enrolled students eligible for free/reduced lunch. The project was to provide comprehensive health appraisals for children prior to their entrance into first grade and to report the findings to the legislature.

The purpose of the project was to determine the effectiveness of such a program in identifying and improving children's health status and the need for and availability of follow-up services. The wording of the proviso required cooperation of the health and education departments at the state and local levels, thus setting the stage for the collaboration that ensued.

The first year was typical of a new project, but we did manage to complete 1,017 exams and were able to report enough information to assure continuation of the project. Major technical assistance from Dr. William Sappenfield, Pediatric Epidemiologist, and Dr. John Watson, pediatrician and Preventive Medicine Resident, University of South Carolina School of Medicine, enabled us to develop history and exam forms specifically targeting 5 year olds and conducive to mass screening use and data collection. (See Appendix I.)

The PSHAP comprehensive health appraisals include all components of an EPSDT exam: a health history is taken, a physical exam completed, and screening for vision, hearing, growth, developmental milestones, speech, dental, anemia, lead poisoning, and tuberculosis are included.

All children in the selected school districts were offered the service, which was provided at school, and parents were encouraged to be present. Forms and process were refined in subsequent years, and we believe the findings are consistently significant enough to encourage expansion in our state:

where -- one out of five children live in poverty; where -- 26% of our children are found not ready to start school; where -- over one-third of our babies are born to mothers at risk and 26% have inadequate pre-natal care;	where -- 32% of our ninth graders drop out by grade 12; and where -- 50 of our 91 school districts have more than 1/2 of their enrolled students eligible for free or reduced lunch, a total of 17,945 children.

During school year 1991--1992, comprehensive health appraisals were provided at no cost to parents, to 2,750 kindergarten students in 40 schools, 18 school districts. Maps showing the distribution of eligible districts in South Carolina and the selected sites that participated during the 1991-92 school year are included in Appendix II.

Participation is voluntary, and 81% of the parents elected to have their children participate. Participation rates have increased each project year, reflective of community acceptance and approval. Project funds are primarily used to support the local, part-time PSHAP coordinator positions in each health district, a pivotal position and key to the project's success. The coordinator serves as liaison, quality assurance monitor, record data manager and case manager for referral completion. Appraisals were done by public health nurses, nurse practitioners, and school nurses at the school site. Post screening pediatric clinics were held for medical evaluation and primary care in several medically underserved areas.

We do not gather demographic data every year, based on consistency of findings the first several years. The following charts (Overhead # 4) from year II are reflective of the demographic findings for project participants:

AGE:	AGE (YR)	FREQUENCY	PERCENT
	4	22	1.1
	5	1,758	91.0
	6	149	7.7
	7	2	0.1

SEX:	SEX	FREQUENCY	PERCENT
	MALE	963	49.9
	FEMALE	968	50.1

RACE:	WHITE	328	17.0
	AM INDIAN	5	0.3
	BLACK	1,580	81.8
	HISPANIC	6	0.3
	ASIAN	10	0.5
	UNKNOWN	2	0.01

We also found that forty-nine percent of the participants had not had a medical exam in the past year, and forty-six percent had never had a dental exam in their lifetime. This finding was not confirmed this project year.

FINDINGS:

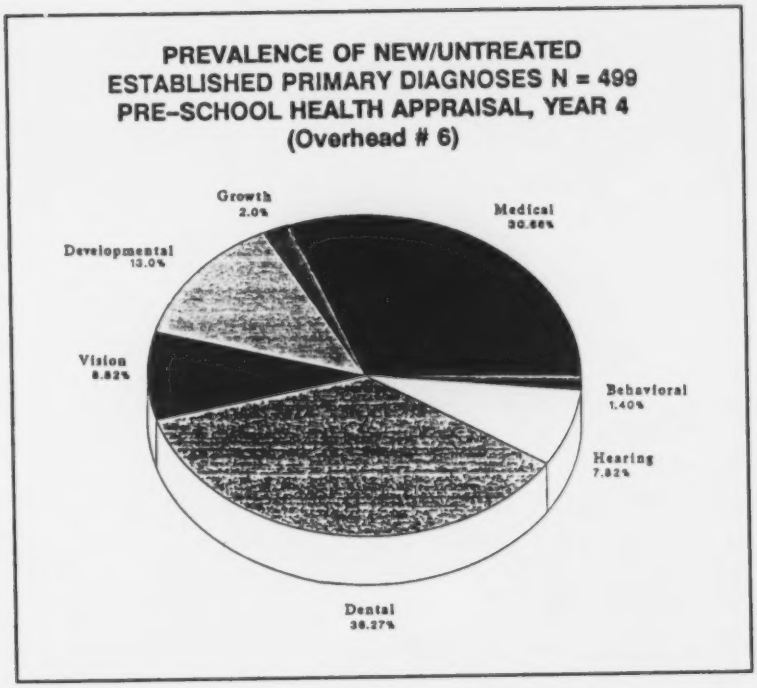
Of all children screened, 1,232 (48%) were referred for evaluation of one or more conditions. A total of 1,776 problems were identified and 773 referrals were completed in the three month time period allotted. Project standards require 2 contacts by letter, one by phone. All project sites exceeded this standard. Multiple attempts were made to assist parents and assure the opportunity for follow-up care. The chart above summarizes the status all referrals for conditions identified.

STATUS OF REFERRALS FOR PSHAP
N = 1,776
(Overhead # 5)

	NUMBER	PERCENT
Referral completed	773	43.5%
Referral not completed	580	32.7%
Already under treatment	422	23.8%
Status unknown	1	00.1%

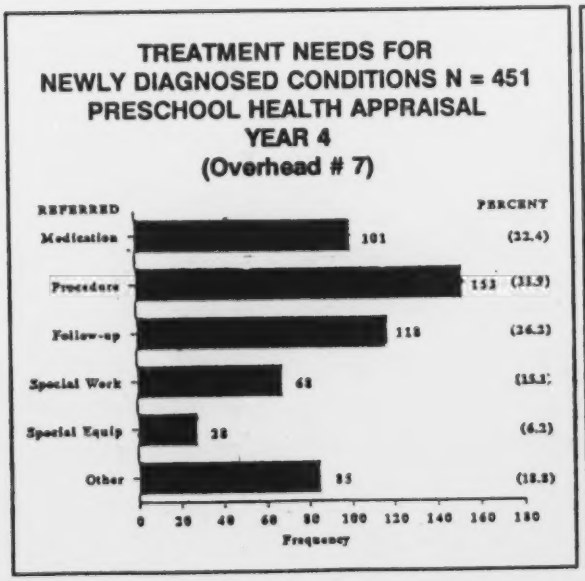
DIAGNOSED CONDITIONS:

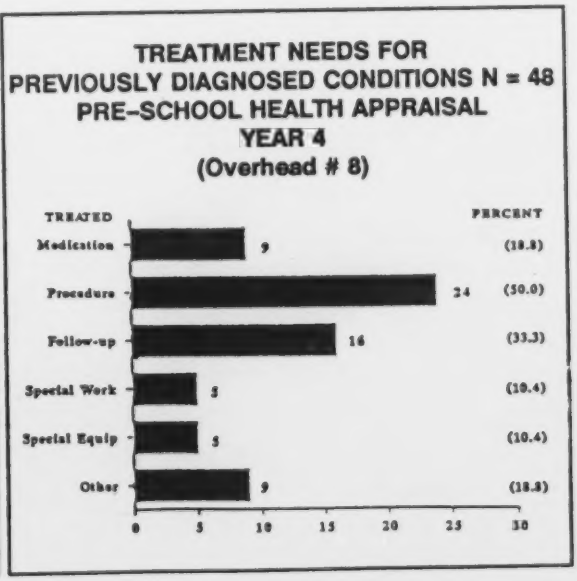
Of the completed referrals, 499 (65%) were confirmed as either <u>new</u> problems or <u>previously diagnosed known</u> conditions that needed care. The graph on the right (Overhead # 6) shows confirmed diagnoses by category.



TREATMENT NEEDS:

Treatment needs for those children identified with new problems and those with previously diagnosed conditions are shown on the following graphs:





SOURCE OF CARE:

The majority of our referrals were handled by the private sector. Private physicians and dentists were the selected source of care for the majority of families, providing care for over two-thirds of the children referred. A listing of all resources utilized are shown in the chart to the right:

SOURCES OF CARE FOR COMPLETED REFERRALS
N = 773
PRE-SCHOOL HEALTH APPRAISAL, YEAR 4
(Overhead # 9)

Health department	83 students	(10.7%)
Private physician	327 students	(42.3%)
Health center	37 students	(4.8%)
Medical/surgical specialist	6 students	(.8%)
Dentist	200 students	(25.9%)
Allied health specialist	34 students	(4.4%)
School health specialist	53 students	(6.9%)
Other	53 students	(6.9%)

PAYMENT SOURCES FOR EVALUATION & CARE:

Payment sources for evaluation and care for conditions identified have remained consistent over the previous years of project experience. About one-third used Medicaid, one-third were self-paid, and one-third were covered by health insurance. However, certain changes have been evident.

PAYMENT SOURCES FOR
COMPLETED REFERRALS N = 773
PRE-SCHOOL HEALTH APPRAISAL PROJECT
YEAR 4
(Overhead # 10)

Medicaid	278 students	(36.0%)
DHEC pediatric clinic	19 students	(2.5%)
Health insurance	104 students	(13.5%)
Special school education	51 students	(6.6%)
Self-paid	231 students	(29.9%)
School Chapter I	20 students	(2.6%)
Military/Champus	—	(0.0%)
PSHAP project	39 students	(5.0%)
CRS	3 students	(0.4%)
Other	55 students	(7.1%)

There is an increase in the use of Medicaid, most likely due to OBRA expansion with increased coverage for this age group, to the declining economy experienced, and to better identification and utilization of all funding resources. Payment sources for all completed referrals are shown in the chart above.

REFERRAL OUTCOMES:

Why do parents who agree to their child's exam not complete the referral for an identified condition? Both the reasons and the response rate vary. In some school districts we know that 80% of the parents will respond to two contacts for a nurse identified referral need. In others, only 20% will respond. Referral completion in the PSHAP project sites required diligent case management action. The Nurse Coordinators made evening and weekend calls, home visits, and extensive efforts to identify or establish resources for care.

REASON REFERRAL NOT COMPLETED BY REFERRAL CATEGORY
PRE-SCHOOL HEALTH APPRAISAL, YEAR 4
(Overhead # 11)

Referable Category	Service Unavail-able	Missed Appoint-ment	No Payment Source	Parent Refused	Unable to Contact	Appoint-ment Pending	Other
Medical	0	11	12	20	46	38	47
Anthropometric	0	0	0	5	14	1	4
Developmental	0	0	1	3	7	14	10
Behavioral	0	0	0	1	0	0	0
Vision	0	0	8	2	12	23	19
Hearing	0	1	4	2	10	15	5
Dental	0	16	54	19	82	126	46
Social	0	0	0	0	0	0	1
TOTAL	0	28	79	51	171	217	132

The project documented the reasons referrals were not completed and found the reasons listed in the chart above for each referral category:

PARENT EDUCATION:

Minor conditions that parents could care for at home were identified in 38% of all children screened. Home treatment Letters (HTL) were sent to educate parents in care for these conditions.

Approximately one-third of the parents indicated their children have behavioral problems that cause them concern. These parents were provided information about resources available in the local community and offered assistance through parenting education programs or mental health counseling.

NUMBER AND PERCENT OF MINOR CONDITIONS
PRE-SCHOOL HEALTH APPRAISAL PROJECT, YEAR 3
(Overhead # 12)

MINOR CONDITIONS		BEHAVIORAL PROBLEMS		FAMILY PROBLEMS	
Dental hygiene	245	Starts fights	116	Family alcohol	43
Overweight	141	Trouble sleeping	145	Family drug	12
Colds	117	Shy/Cries a lot	248	Family nervous	71
Occlusive cerwax	112	Bad temper	303	Other family prob	13
Skin infections	72	Afraid/Insecure	297		
Short stature	29	Disobedient	86		
Sore throat	25	Cries when left	115		
		Other behav.	30		
Total	740	Total	1,127	Total	139

A number of parents indicated they had family problems with one or more members. These respondents were contacted directly to offer assistance.

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Most of our selected project sites do not staff school nurses. These are problems that a school nurse would be detecting and providing parent education for on a continuum.

WHAT WE LEARNED:

1. We can target populations for public health services using the free/reduced school lunch information for selection of sites and to help us set priorities for supplementing school health programs.

2. Children entering school do have unknown health problems that can be detected by nurse/nurse practitioner teams.

3. We can access populations most at risk through school/public and health collaborative efforts.

4. We can mobilize a community to maximize available public and private resources for care.

5. We can increase community and school staff awareness of the importance of health as a vital component of success in school.

The South Carolina PSHAP Project is a model for consideration as you plan ways to offer preventive health screening at developmentally appropriate intervals.

APPENDIX I

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

****
* PRE-SCHOOL HEALTH APPRAISAL PROJECT *
****

TRACKING LOG INSTRUCTIONS

The purpose of this tracking log is to assist you in knowing the status of each student throughout the PSHAP appraisal process and for data collection. It provides:

- a reference document for each classroom, showing up-to-date status of all appraisals components.
- a tool for monitoring for quality assurance purposes.
- a data collection instrument for compiling state and local reports.

	COLUMN	
1.	STUDENT PSHAP ID #	Record in **numerical order** each student's individual PSHAP # and name from the Parent Questionnaire (DHEC 735). If student transfers before completion, reassign new number and note new number in column #18 (Reason for Referral).
2.	PARENT QUESTIONNAIRE RETURNED	Check (√) column 2 to indicate that each student's Confidential Parent Questionnaire (DHEC 735) is **RETURNED** with the parent/guardian permission **SIGNED**. A **BLANK** space indicates that the child did <u>not</u> return the form. Write **R** to indicate the form was returned, but the parent did not want the child to participate.
3.	NAME	Record each student's full name: last name, first, middle initial.
4.	SEX	Record the student's sex (**M** = male, **F** = female).
5.	RACE	Record the student's race (**W** = white, **B** = Black, and **O** = other.)
6.	PHYSICAL COMPLETED	Place a check in this column when all components of the **Physical Exam** (DHEC 740) have been **completed.**
7.	SCREENS COMPLETED	Place a check in this column when all components of the **Screening** (DHEC 739) have been **completed.**

8.	PPD GIVEN	If all PPDs were given on the same day, write the date PPD's were given in the space provided (____/____/____). Place a check (√) in this column for each student who had a PPD. If PPDs given with exam on multiple dates, document date given.
9.	PPD READ	Note the appropriate results of the PPD (+ = positive, - = negative, or NR = Not Read).
10.	RESCREEN VISION	Check this column only if child <u>failed</u> initial screening for vision and RESCREEN is needed. Indicate by crossing the check mark when rescreen is completed.
11.	RESCREEN HEARING	Check this column if child <u>failed</u> initial screening for hearing and RESCREEN is needed. Indicate by crossing the check mark when rescreen is completed.
12.	RESCREEN DDST	Check this column if DDST <u>results were abnormal, questionable, or untestable</u>, and RESCREEN is needed. Indicate by crossing the check mark when rescreen is completed.
13.	RESCREEN BP	Check this column if child <u>failed</u> the blood pressure screening on the first two screens and RESCREEN is needed. Indicate by crossing the check mark when rescreen is completed.
14.	EXAM COMPLETED	Place a check in this column to indicate that <u>all components</u> (DHEC 739 & 740) of the appraisal were completed.
15.	TOTAL # HTL'S	Use this column to compile the <u>total number</u> of Home Treatment Letters (HTL's) initiated for this child.
16.	TOTAL # OF REFERRALS	Write the <u>total #</u> of referrals made for this child.
17.	REASON(S) FOR REFERRAL	Write the reason for each referral made for this child, i.e. dental, vision (20/20, 20/40), etc.
18.	MEDICAID ELIGIBLE	Check (√) this column if the child is eligible for Medicaid.

CLASS/TEACHER

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

****
* PSHAP TRACKING LOG *
****

HEALTH DISTRICT: _____

SCHOOL DISTRICT: _____

SCHOOL: _____

STUDENT PSHAP ID #	PARENT QUESTIONNAIRE RETURNED	NAME	SEX	RACE	PHYSICAL COMPLETED	SCREENS COMPLETED	PPD GIVEN (__/__/__)	PPD READ	RESCREEN VISION	RESCREEN HEARING	RESCREEN DDST	RESCREEN BP	EXAM COMPLETED	TOTAL # H'L'S	TOTAL # REFERRALS	REASONS FOR REFERRAL(S)	MEDICAID NUMBER

DHEC 742 (Rev. 7/92)

This form has been reduced to 77% of its original size.

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

****
PRE-SCHOOL HEALTH APPRAISAL PROJECT
****

CONFIDENTIAL PARENT QUESTIONNAIRE: PARENT INSTRUCTIONS

This form serves several purposes:

1. To compile demographic information on each participant for referral and follow-up purposes.
2. To obtain parental permission for the health assessment.
3. To obtain a health history.
4. To assign a master identification number to each participant.

Step-by-Step Instructions for Each Line:

1. Child's Name: Enter last name, first name, middle name.
2. Teacher: Enter teacher's name to identify child's class.
3. School: Enter name of school.
4. Date of Birth: Enter date, month/day/year (digital).
5. Sex: Check appropriate category.
6. Race: Check one as appropriate.
7. Child's Address: Enter mailing address, city, state, zip.
8. Home phone: Enter home phone or contact number.
9. Work Phone: Enter work phone contact number.
10. Child's Parent or Guardian: Enter name of contact person.
11. Parent/Guardian Signature: Legal authorization must be signed before exam.
12. Questions:
    1. Check appropriate block(s) to indicate where child is taken for medical care when sick.
    2. Check block to identify the main source of payment for medical care.

3. Check block to indicate when the child had last medical check-up.

4. Check block to indicate when child had last dental check-up.

5. Check yes and list any known medical condition(s) this child presently has.

6. Check yes and list all medications the child takes on a daily basis.

7. Check block(s) to indicate any medical problem(s) the child has ever had.

8. Check yes and list every food, medicine, bee or insect that the child has an allergic reaction to.

9. Check yes if the child has previously been skin tested for TB.

10. Check yes if the child has ever had a chest x-ray for TB.

11. Check yes if the child has been treated with medication for TB.

12. Check yes if this child or a sibling has ever had lead poisoning.

13. Check yes if this child's dwelling place was built before the year 1960.

14. Check appropriate block(s) to indicate known health conditions that your child has, or has had as listed in each body system category.

15. Return signed form to the child's teacher as indicated on the bottom of page 4.

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Project ID# __/__/__/__/__/__
1 2 3 4 5 6

****
PRE-SCHOOL HEALTH APPRAISAL PROJECT
****

CONFIDENTIAL PARENT QUESTIONNAIRE:

Do Not Write In This Space OFFICE USE ONLY

Child's Name: _____
(Last) (First) (MI)

Teacher: _____

School: _____

Child's Date of Birth: _____ __/__/__ (7-12)

Sex: ___ Male ___ Female Sex ___ 13

Race: ___White ___Hispanic ___Black Race ___14
___Unknown ___Asian ___American Indian

Child's Home Address: _____

Home Phone: _____

Work Phone: _____

Child's Parent or Guardian: _____

PERMISSION FOR SERVICES

I GIVE MY PERMISSION FOR MY CHILD TO HAVE THIS HEALTH SCREENING, AND I UNDERSTAND THE RESULTING INFORMATION MAY BE SHARED WITH SCHOOL HEALTH PERSONNEL.

PARENT/GUARDIAN SIGNATURE:

_____ **DATE:** ___/ ___/___

PLEASE CHECK ALL ANSWERS THAT APPLY:

1. Where do you take your child when he is sick?

[] doctor's office ___ 15
[] urgent care center/hospital emergency room ___ 16
[] other_____ ___ 17
_____

Do Not Write In This Space OFFICE USE ONLY

2. What is your **main** source of payment for medical care? (Check only one.) NOTE: If Medicaid, please give number. ___ 18

[] Health Insurance
[] Medicaid (number_____) ___ ___ ___ ___ ___ (19-23)
[] Champus/Military Base
[] Self-Pay ___ ___ ___ ___ ___ (24-28)

3. When did your child have a medical check-up? ___ 29

[] In the last year [] More than two years ago
[] 1-2 years ago [] Never

4. When did your child have a dental checkup? ___ 30

[] In the last year [] More than two years ago
[] 1-2 years ago [] Never

CHILD'S HEALTH HISTORY

5. Does your child have medical problem(s)? If yes, please list:

[] Yes 1. _____
[] No 2. _____ ___ 31
3. _____

6. Does your child need to take any medicine every day? If yes, please list:

[] Yes 1. _____
[] No 2. _____ ___ 32
3. _____

7. Has your child **ever** had any of the following **medical problems**? (Check all that apply.)

[] Asthma	[] Hemophilia (bleeding problems)	___ ___ (33-34)
[] Anemia	[] Meningitis	___ ___ (35-36)
[] Cancer	[] Rheumatic Fever	___ ___ (37-38)
[] Diabetes	[] Sickle Cell Disease (not trait)	___ ___ (39-40)
[] Epilepsy (fit)	[] Other_____	___ ___ (41-42)

8. Is your child **allergic** to any of the following:

Food(s) -- Please write any foods your child is allergic to.

[] Yes 1. _____
[] No 2. _____ ___ 43

Medicine(s) -- Please write any medicines your child is allergic to.

[] Yes
[] No

1. _____
2. _____

Bee or other insect -- Please write any insects your child is allergic to.

[] Yes
[] No

1. _____
2. _____

9. Has your child ever been skin tested for TB?

[] yes - (results _____)
[] no

10. Did your child ever have a chest x-ray for TB?

[] yes - (results _____)
[] no

11. Did your child ever have to take medication for TB?

[] yes
[] no

12. Has your child or <u>any</u> of your children ever had lead poisoning?

[] yes
[] no

13. Was your home built before 1960?

[] yes
[] no

HEALTH PROBLEMS

Does your child have any of the problems listed below?
Please check all that apply:

<u>HEAD & MOUTH</u>

[] Has headaches more than 4 times a month
[] Has lost consciousness or been knocked out
[] Faints sometimes
[] Has toothaches
[] Other_____

<u>EYES & EARS</u>

[] Has trouble hearing
[] Uses a hearing aid
[] Has ear infections often (3 in 6 months)
[] Has trouble seeing
[] Wears glasses
[] Eye crosses or wanders
[] Other_____

<u>LUNGS & HEART</u>

[] Has trouble breathing or shortness of breath
[] Has a heart problem or heart condition
[] Had a heart murmur at last checkup
[] Other_____

Do Not Write In This Space OFFICE USE ONLY

___ 44

___ 45

___ 46

___ 47

___ 48

___ 49

___ 50

___ 51
___ 52
___ 53
___ 54
___ 55

___ ___ (56-57)
___ ___ (58-59)
___ ___ (60-61)

___ 62

___ 63
___ 64
___ 65
___ 66

Do Not Write In this Space
OFFICE USE ONLY

ABDOMEN

[] Has a hernia ___ 67
[] Messes (poops) in underpants - more than 1 time per month ___ 68
[] Wets pants in the daytime - more than 1 time per month ___ 69
[] Wets the bed at night more than 1 time per week ___ 70
[] Has had a bladder or urine infection treated by a doctor ___ 71
[] Other_____ ___ 72

MUSCLES/JOINTS/NERVES

[] Has pain in the arms, legs, joints or back ___ 73
[] Limps or has trouble walking ___ 74
[] Seems clumsy or has trouble with balance ___ 75
[] Other_____ ___ 76

BIRTH HISTORY

[] Had a birth defect_____ ___ 77
(Please specify)
[] Had trouble breathing ___ 78
[] Born early (premature) ___ 79
[] Other problems_____ ___ 80

BEHAVIOR

[] Often starts fights with others ___ 81
[] Has trouble sleeping/ bad dreams ___ 82
[] Is very shy/ cries a lot/ moody ___ 83
[] Has a "bad temper"/ tantrums ___ 84
[] Often afraid of things/ insecure ___ 85
[] Is very disobedient ___ 86
[] Always cries when I leave ___ 87
[] Other_____ ___ 88

FAMILY PROBLEMS

Does anyone in this family need help for:

[] A drinking or alcohol problem ___ 89
[] A drug problem ___ 90
[] A nervous problem ___ 91
[] Other_____ ___ 92

PLEASE SIGN PERMISSION ON FRONT &
RETURN TO YOUR CHILD'S TEACHER WITHIN DAYS

THANK YOU

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

****
PRE-SCHOOL HEALTH APPRAISAL PROJECT
****

SCREENING FORM INSTRUCTIONS

Introduction:

1. All screeners are responsible for reviewing and adhering to the standard procedures as described in the Children's Health Services Manual.

2. The front of this form is reserved for documentation of screening findings only. Comments and/or progress notes may be written on the back of this form in the designated area.

3. Use leading zeroes for all numbers less than 100 [ex: 094].

4. The referral criteria are listed in the right column (Referable Conditions). When a condition falls within those criteria, the child must be referred. This is not at the discretion of the examiner.

5. Record student ID # from the Confidential Parent Questionnaire (DHEC 735) Name Sex and Date of Birth from school roster.

Growth:

1. Record actual height in inches to nearest 1/2 inch; weight in pounds to the nearest 1/2 pound; and age in years and months. Record height and weight in **DECIMAL** not fraction form (i.e., 1/2 = .5).

2. Use growth grid and accuplot to determine growth percentiles. Charting on the grid is not necessary unless health record is retained and filed.

3. Check any referable condition and refer as follows:

   - weight for height >95th percentile, send home treatment letter (HTL-Overweight).
   - weight for height <5th percentile, refer to PMD or HD.
   - height for age <5th percentile, send home treatment letter (HTL - Short Stature).

Vision:

1. Use Snellen E Chart only.

2. Test each eye separately and document findings.

3. Check box if screened with glasses.

4. Check referable conditions, i.e.:

   - vision tests 20/40 or poorer in either eye (unable to read more than half of 20/30 line).
   - 2 line difference between eyes (ex: L 20/20, R 20/40.

5. Check box to indicate need for rescreen at the time of the exam.

6. Repeat test within 2 weeks to confirm findings prior to referral for professional eye exam. Document rescreen findings on screening form and initiate a Referral Form as indicated.

Hearing:

1. Record findings as P (pass)/ F (fail) for each ear and each cycle.

2. Failure to hear 1000Hz - 2000Hz at 20 dB or 4000Hz at 25 dB in either ear constitutes failure.

3. Examine all primary failures otoscopically. If ear canal is obstructed:

   - obstruction foreign object, refer to PMD immediately.
   - obstruction cerumen, send home treatment letter (HTL - Earwax).

4. If ear canal is not obstructed, check box to indicate need for re-screen.

5. Rescreen within 2 weeks, document findings on screening form and refer all failures for further evaluation.

Speech:

1. Use chart to identify percentile for DASE score and record percentile rank in screening column.

2. Check appropriate block in screening column to show child is understandable at least 1/2 of the time.

3. Check appropriate "Refer" column to indicate reason for referral:

   - DASE 15 percentile
   - Not understandable 1/2 of the time.

4. Refer abnormals to school speech pathologist.

Developmental:

1. Use Denver II Form. Indicate on form: normal or needs rescreen (abnormal, questionable, or untestable).

2. Abnormal, questionable, or untestable requires rescreen.

3. Rescreen in 2 -- 12 weeks to confirm Denver II findings prior to referral. Indicate results as normal or needs referral. If on rescreen, results are abnormal or untestable, referral is required. Questionable results on rescreen may need nursing judgement to determine if referral is needed.

4. Check appropriate block to indicate area(s) failed (# 61, 62, 63, 64).

Blood Pressure:

1. Record first reading on screening form

2. If first reading is within normal limits, no further readings are required.

3. If first reading falls in the 99th percentile (systolic >124 or diastolic >84), confirm finding on the same visit and immediately refer for medical evaluation.

4. If first reading falls in the 95th percentile (systolic >116 or diastolic >76),

   - recheck for a 2nd screening, after a period of rest, and document on the screening record.
   - recheck for the 3rd reading on a separate day and average the three readings. If the average for three measurements is >95th percentile, refer for medical evaluation. Document rescreen findings and record average in designated spaces.

Blood Tests:

1. Delay these tests until all other components of screening and physical exam are completed.

2. Refer abnormal hematocrit (<30) or hemoglobin (<10) for evaluation and draw blood for lead testing.

3. Check history and draw blood for lead testing if there is a history of lead poisoning or if home was built before 1960. Refer for medical evaluation if blood lead is > 20.

Tuberculosis:

1. If documented that child has had a previous test read in the last year, do not give. Indicate in the designated block (# 94).

2. Check history and do not give if child has had a <u>previous</u> <u>positive</u> TB skin test. Indicate in the designated block (# 95).

3. Administer 0.1cc PPD intradermal in left forearm (# 96).

4. All PPDs must be read 48-72 hours after given.

   - Refer all positive PPDs 10 mm or greater to PMD or Tb Program. Check (# 103) to indicate positive referral.
   - PPD not read due to absence, check (# 97).
   - PPD Within Normal Limits, check (# 98).

Office Mechanics and Filing:

1. A Referral Follow-up Form or Home Treatment Letter (HTL) must be filled out at the time of the exam for each identified condition as appropriate.

2. Staple all Appraisal Forms for each child together with Parent Questionnaire first, Screening Form second, Physical Exam Form last.

3. Maintain records for each school in separate box.

4. Original records will be maintained by the health district with copies to the school at the request of the School Nurse. Original records should be included as part of the Child Health Record if the child is a Health Department patient. All others can be retained in a hanging file.

5. Completed Logs and all original Referral Follow-up Forms should be sent to Central Office as each school is finished. The deadline for project completion is March 31.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

* PRE-SCHOOL HEALTH APPRAISAL PROJECT *

SCREENING FORM

PROJECT I.D. # ___ ___ ___ ___ ___ ___
1 2 3 4 5 6

NAME: _____

SEX: M ☐ 7 F ☐ 8

DATE OF BIRTH: ___ ___/___ ___/___ ___
9 10 11 12 13 14

SCREENING	REFERABLE CONDITIONS
GROWTH Height: ___ ___ . ___ (15-17) Weight: ___ ___ . ___ (18-20) Age: ___ years ___ ___ months (21-23)	Weight for height > 95th HTL ☐ 52 Weight for height < 5th ☐ 53 Height for age < 5th HTL ☐ 54
VISION R L Screen 20/___ ___ 20/___ ___ (24-27) ☐ Needs Rescreen 20/___ ___ 20/___ ___ (28-31) Screened with glasses ☐ (32)	20/40 or poorer on rescreen ☐ 55 2 line difference between eyes ☐ 56
HEARING Indicate P or F for each cycle Screen 1000 | 2000 | 4000 Left ___ | ___ | ___ (33-35) Right ___ | ___ | ___ (36-38) ☐ Needs Rescreen 1000 | 2000 | 4000 Left ___ | ___ | ___ (39-41) Right ___ | ___ | ___ (42-44)	Ear occluded with wax HTL ☐ 57 Failed to hear at one or more cycles on rescreen ☐ 58
SPEECH Denver Articulation Screening Exam Percentile Rank ___ ___ (45-46) Understandable ___ (47)	Abnormal DASE < 15 percentile ☐ 59 Not understandable at least 1/2 of the time ☐ 60
DEVELOPMENTAL -- Denver II ☐ Normal (48) ☐ Needs Rescreen (abn, quest, untest) (49) Rescreen ☐ Normal (50) ☐ Needs Referral (abn, quest, untest) (51)	Areas with delays or cautions requiring referral Social ☐ 61 Fine Motor ☐ 62 Language ☐ 63 General motor ☐ 64

DHEC 739 (Rev. 7/92)

BEST COPY AVAILABLE

BLOOD PRESSURE

1st Reading ___ ___ ___/___ ___ ___ (65-70)

2nd Reading ___ ___ ___/___ ___ ___ (71-76)

☐ Needs Rescreen

3rd Reading ___ ___ ___/___ ___ ___ (77-82)

Average: ___ ___ ___/___ ___ ___ (83-88)

> 99th % (>124/or>84) ☐ 101

> 95th % (116/or>76) (Average of 3 Readings) ☐ 102

BLOOD TESTS

Hematocrit ___ ___ (89-90)

< 30% HCT - Refer and draw blood lead ☐ 103

Hgb. ___ ___ ___ (91-93)

< 10 mg Hgb. - Refer and draw blood lead ☐ 104

Blood Lead ___ ___ (94-95)

> 20 Blood Lead - Refer ☐ 105

TUBERCULOSIS

Not given -- Documented test in past year ☐ (96)

Not given -- Hx of previous positive test ☐ (97)

PPD Given ☐ (98)

PPD Not Read ☐ (99)

PPD WNL ☐ (100)

Positive PPD (10 mm, or greater) ☐ 106

*** NURSE'S NOTES ***

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

****
* PRE-SCHOOL HEALTH APPRAISAL PROJECT *
****

Physical Exam Instructions

Introduction:

1. All examiners are responsible for reviewing the physical assessment section of the Children's Health Services Manual, Section IV Patient Assessment with special attention to five year olds.

2. This form is reserved for documenting physical appraisal findings only. Specific items identified direct the examiner's attention to conditions prevalent and significant among 5 year olds. Relevant observations can be briefly described in the comment section for each category. Use the tracking log to document referral follow-up activities.

Heading:

1. Record patient ID # from the "Confidential Parent Questionnaire" (DHEC-735) in the space provided at the top right hand side of the form.

2. Record name of child (last, first, M.I.) on the line provided for that purpose.

3. Check appropriate block to confirm sex of child.

General Instructions:

1. Perform physical appraisal using the form to guide you in reviewing each of the body systems as listed.

2. Each positive finding that is referable must be indicated by checking the designated block. A checked box means this child is referred.

3. A "Referral/Follow-Up Summary Form" must be filled out for each of the referable (checked) conditions identified.

4. A Home Treatment Letter for minor conditions as indicated (HTL) should be filled out at the time of the exam.

5. Complete both sides of the form.

Signature:

1. Sign and date form on designated line at the bottom of side 2.

2. Check appropriate block to indicate if exam was "WNL" or "Unable To Exam" if child refused.

OFFICE MECHANICS and FILING:

1. Fill in the ID number and the first 3 lines on the Referral Follow-up Summary Form (DHEC 741) or Home Treatment Letter at the time of the exam for each identified condition as each exam is completed.

2. Return completed Physical Exam Form to PSHAP coordinator for retention and disposition.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

****
* PRE-SCHOOL HEALTH APPRAISAL PROJECT *
****

PHYSICAL EXAM FORM

PROJECT I.D. # ___ ___ ___ ___ ___ ___
1 2 3 4 5 6

NAME: _____
Last, First Middle

Sex: Male ☐ 7 Female ☐ 8

****

* Fill in Project I.D. from Parent Survey form.

* ALL CHECK MARKS REQUIRE REFERRAL OR NTL.
USE COMMENTS TO NOTE SOMETHING WHICH IS NOT REFERRED.

****

GENERAL APPEARANCE:

☐ 9 FLK - abnormal appearance
☐ 10 Extreme obesity
☐ 11 Other: _____

Comments: _____
_____
_____

NOSE:

☐ 22 Polyps
☐ 23 URI (NTL)
☐ 24 Other: _____

Comments: _____
_____
_____

****

SKIN:

☐ 12 Eczema (NTL)
☐ 13 Infection or infestation (scabies, ringworm, impetigo) (NTL)
☐ 14 Multiple or unusual scars
☐ 15 Tumors, lumps, abnormal nevus
☐ 16 Rash of unknown origin
☐ 17 Other: _____

Comments: _____
_____
_____

EYES:

☐ 25 Abnormal cover test
☐ 26 Strabismus
☐ 27 Ptosis - dropping eyelid
☐ 28 Red reflex, abnormal or absent
☐ 29 Conjunctivitis
☐ 30 Other: _____

Comments: _____
_____
_____

****

HEAD:

☐ 18 Lice/nits (NTL)
☐ 19 Abnormal hair pattern
☐ 20 Abnormal size/shape
☐ 21 Other: _____

Comments: _____
_____
_____

EARS:

☐ 31 Otitis externa
☐ 32 Otitis media
☐ 33 Foreign body
☐ 34 Draining ear
☐ 35 Retracted tympanic membrane
☐ 36 Other: _____

Comments: _____
_____
_____

****

COMPLETE OTHER SIDE.

ORAL CAVITY:

- ☐ 37 Serious tooth decay or caries
- ☐ 38 Severe overbite, underbite or malocclusion
- ☐ 39 Dental care (HTL)
- ☐ 40 Pharyngitis (HTL)
- ☐ 41 Other: _____

Comments: _____

GENITALIA: (Male)

- ☐ 54 Undescended testicles
- ☐ 55 Inguinal hernia or hydrocele
- ☐ 56 Discharge/redness/inflammation/infection
- ☐ 57 Dark pubic hair
- ☐ 58 Other: _____

Comments: _____

NECK:

- ☐ 42 Enlarged thyroid
- ☐ 43 Abnormal lymph node(s) (>2cm immobile or tender)
- ☐ 44 Other: _____

Comments: _____

GENITALIA: (Female)

- ☐ 59 Redness/inflammation/discharge/infection
- ☐ 60 Dark pubic hair
- ☐ 61 Other: _____

Comments: _____

CHEST:

- ☐ 45 Wheezes
- ☐ 46 Breast enlargement
- ☐ 47 Other: _____

Comments: _____

RECTUM:

- ☐ 62 Warts
- ☐ 63 Bruises
- ☐ 64 Other: _____

Comments: _____

HEART:

- ☐ 48 Abnormal rate or irregular rhythm (>150 or <68 on 3 readings)
- ☐ 49 Abnormal heart sounds (clicks/splits)
- ☐ 50 Murmur
- ☐ 51 Other: _____

Comments: _____

BONES/JOINTS/MUSCLES:

- ☐ 65 Abnormal gait or limp
- ☐ 66 Abnormal muscle tone
- ☐ 67 Abnormal range of motion
- ☐ 68 Spinal deviation
- ☐ 69 Other: _____

Comments: _____

ABDOMEN:

- ☐ 52 Umbilical hernia
- ☐ 53 Other: _____

Comments: _____

NEUROLOGY:

- ☐ 70 Poor coordination/reflexes
- ☐ 71 Other: _____

Comments: _____

- ☐ 74 Exam WNL
- ☐ 75 Unable to examine

Signature of Examiner _____ Date __/__/__

*** STAPLE COMPLETED PHYSICAL EXAM FORM TO BACK OF PARENT SURVEY FORM. ***

****
* PRE-SCHOOL HEALTH APPRAISAL PROJECT *
****

REFERRAL/FOLLOW-UP SUMMARY INSTRUCTIONS

INTRODUCTION:

This form is used to document all referrals made for conditions identified during the health assessment and to provide an individual tracking record to document the outcome of the referral. The form must be completed for each condition, thus a child may have more than one Referral Follow-up Summary Form.

Use this form only for referable conditions. Do not use for those minor conditions where instructions are given for home care (Home Treatment Letter).

Record the Student ID # from the "Confidential Parent Questionnaire" (DHEC 735) in the space provided at the top right hand side of the form. The name of school (line 2) can be filled in ahead of time for convenience.

Use Student Data Edit Screen information from the school to assist in referral follow-up activities. Computerized mailing labels may be available from the school if you wish to mail information to the parent/guardian.

HEADING:

1. Record name of child (last, first, M.I.) on line 1.

2. Record name of school on line 2.

3. State condition that was identified as needing referral.

4. If child is already being treated for this condition, check yes and process form (no further action is required).

   If child has not been seen for this condition or needs further treatment for this condition, check yes and continue.

5. Check appropriate block to indicate whether referral was or was not completed.

   - write total number of contacts made for this referral (regardless of referral outcome).
   - check/"COMPLETED" if referral was completed and skip to question # 7.
   - check/"NOT COMPLETED" if referral was not completed.

6. If the referral was not completed, check reason(s) why and process form (no further information required on form).

7. Check the appropriate block(s) to identify **where** the child was referred.

8. Check the appropriate block(s) to identify **payment source**.

9. Check appropriate block to indicate results of referral

   -- **Yes** - If diagnosed, state the primary diagnosis identified by the provider.
   -- **No** - If diagnosis was <u>not</u> related to the referred condition, check this box. Write any other diagnoses made in line # 12.
   -- **No** - If condition was WNL, check **NO**, and stop here.

10. Check the appropriate block to indicate whether the condition identified in question # 9 is a **newly diagnosed** condition or a previously known condition, and whether the condition requires treatment.

11. Check appropriate block(s) to identify the **kind of treatment** required. This can be determined from the provider's report or from information given by the parent.

   -- Periodic follow-up means return annually or within 1 year.
   -- Special equipment includes glasses, braces, appliances, hearing aids, etc.
   -- Procedure includes therapy (speech, OT, PT, etc.)

12. List all **other diagnoses** made which do not relate to the primary condition but were identified as a result of this referral.

13. **Sign and date** completed form as indicated.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF CHILDREN'S HEALTH

****
PRE-SCHOOL HEALTH APPRAISAL PROJECT
****

REFERRAL/FOLLOW-UP SUMMARY FORM

PROJECT I.D. __ __ __ __ __ __
1 2 3 4 5 6

* Complete a separate form for each problem needing referral.
* Do not use this form for minor conditions (HTL).

Do Not Write In This Space OFFICE USE ONLY

1. Name: _____

2. School: _____

3. Referred for: _____ __ __ __ 7 8 9

4. Is child presently under treatment for this condition?

☐ Yes -- STOP HERE __ 10

☐ No

☐ Unknown

5. Referral Status:

____ # Contacts Made __ 11

☐ Completed - Skip to question # 7. __ 12

☐ Not Completed

6. If referral not completed, check reason(s) why:

☐ service not available ☐ missed appointment __ __ 13-14

☐ no payment source ☐ parent/guardian refusal __ __ 15-16

☐ unable to contact ☐ appointment pending __ __ 17-18

☐ condition self-resolved ☐ moved/transferred __ __ 19-20

☐ other _____ __ __ 21

STOP HERE IF REFERRAL NOT COMPLETED.

7. Where was the child referred for evaluation of the condition? (Check all that apply.)

☐ Health department clinic ☐ Private physician or clinic __ __ 22-23

☐ Health center or clinic ☐ Med/surg specialist or clinic __ __ 24-25

☐ Dentist/dental clinic ☐ Private allied health specialist __ __ 26-27

☐ School health or educ. specialist ☐ Other _____ __ __ 28-29

Do Not Write In This Space OFFICE USE ONLY

8. How was the referral to obtain this diagnosis actually paid for? (Check all that apply.)

☐	Medicaid	☐	DHEC Clinic	__ __ 30-31
☐	Health insurance	☐	School special ed	__ __ 32-33
☐	Self pay	☐	School Chapter I	__ __ 34-35
☐	Military base or Champus	☐	PSHAP Project Funds	__ __ 36-37
☐	CRS	☐	Other	__ __ 38-39

9. Was a primary diagnosis established?

☐ Yes_____ __ 40
(Primary diagnosis related to the referred condition.)

☐ No (Diagnosis was not related to referred condition -- #12.)

☐ No (Condition was WNL - Stop here.)

41 42 43 44

10. Was the primary diagnosis (question # 9) a :

☐ New diagnosis, requiring treatment. __ 45

☐ New diagnosis, no treatment required.

☐ Old diagnosis, requiring treatment.

☐ Old diagnosis, no treatment required.

11. List the kind of new treatment needed for the diagnosed condition: (Check all that apply.)

☐	Medication	☐	Procedure	__ __ 46-47
☐	Periodic Follow-up (up to 1 year)	☐	Special Work-up	__ __ 48-49
☐	Special Equipment	☐	Other _____	__ __ 50-51

12. List any other diagnoses made as a result of this referral: __ 52

1. _____ 53 54 55 56
2. _____ 57 58 59 60
3. _____ 61 62 63 64

SIGNATURE:_____ DATE:_____

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PRESCHOOL HEALTH APPRAISAL PROJECT

PARENT REPORT

DEAR PARENT:

YOUR CHILD, _____, RECENTLY HAD A HEALTH APPRAISAL THROUGH THE PRESCHOOL HEALTH APPRAISAL PROJECT (PSHAP) CO-SPONSORED BY YOUR SCHOOL AND HEALTH DEPARTMENT.

YOUR CHILD WAS GIVEN:

- A PHYSICAL EXAMINATION
- VISION AND HEARING SCREENING
- HEIGHT AND WEIGHT ASSESSMENT
- SPEECH AND DEVELOPMENTAL SCREENING
- DENTAL SCREENING
- BLOOD TESTING FOR IRON AND LEAD LEVELS
- AND A TUBERCULIN SKIN TEST

THE RESULTS OF YOUR CHILD'S APPRAISAL WERE:

_____ NO PROBLEMS WERE NOTED

_____ THE FOLLOWING PROBLEM(S) WERE NOTED (SEE ATTACHED)

A NURSE WILL BE CONTACTING YOU IF WE DO NOT HEAR FROM YOU ABOUT THE PROBLEM NOTED.

THANK YOU FOR HELPING US
KEEP YOUR CHILD HEALTHY

HEALTHY CHILDREN LEARN BETTER

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
PRESCHOOL HEALTH APPRAISAL PROJECT

VISION SCREENING REFERRAL

DEAR PARENT:

THE RESULTS OF YOUR CHILD'S VISION TEST INDICATE THE NEED FOR A MORE COMPLETE EYE EXAMINATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST. THE FINDINGS OF OUR VISION SCREENING TEST ARE WRITTEN ON THE BACK OF THIS LETTER. TAKE THIS FORM WITH YOU WHEN YOU GO TO THE EYE SPECIALIST.

UNCORRECTED VISION DISORDERS CAN AFFECT YOUR CHILD'S ABILITY TO LEARN. IT IS IMPORTANT THAT YOU COMPLETE THIS REFERRAL AND RETURN THE INFORMATION ABOUT YOUR CHILD'S VISION TO THE SCHOOL.

THANK YOU FOR KEEPING YOUR CHILD HEALTHY. IF YOU HAVE ANY QUESTIONS OR NEED HELP IN GETTING CARE, PLEASE CONTACT ME.

_____ NAME

_____ PHONE #

PLEASE HAVE THE RESULTS OF THE EYE EXAM WRITTEN ON THE BACK OF THIS LETTER AND RETURN IT TO YOUR CHILD'S TEACHER

HEALTHY CHILDREN LEARN BETTER

FINDINGS: SCHOOL SCREENING TEST DATE: _____

RESULTS:

Visual Acuity:	Rt.	Lt.
With glasses	_____	_____
Without glasses	_____	_____

Testing Method(s):

Snellen _____

Snellen E _____

Other _____

Comments: _____

_____

****

REPORT OF EYE EXAMINATION: Date: _____

Visual Acuity:	Rt.	Lt.
Without Correction	_____	_____
With Correction	_____	_____

Diagnosis or explanation of eye condition: _____

_____

PLAN OF TREATMENT:

Glasses prescribed Yes _____ No _____

Worn constantly ____ Part-time wear ____ (Please describe)

_____

Recommendations for School: _____

_____

When should this child be re-examined? _____

_____

Examiner's Printed Name: _____ Signature: _____

Office Phone: _____ Date: _____

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PRESCHOOL HEALTH APPRAISAL PROJECT

HEARING SCREENING REFERRAL

DEAR PARENT:

THE RESULTS OF YOUR CHILD'S SCREENING TEST SHOWS THE NEED FOR FURTHER EVALUATION OF HIS/HER HEARING. THE FINDINGS OF THE SCHOOL HEARING TEST ARE RECORDED ON THE BACK OF THIS LETTER.

PROLONGED HEARING LOSS CAN AFFECT YOUR CHILD'S ABILITY TO LEARN. IT IS IMPORTANT THAT YOU COMPLETE THIS REFERRAL AND RETURN IT TO THE SCHOOL WHEN COMPLETED.

THANK YOU FOR KEEPING YOUR CHILD HEALTHY. IF YOU HAVE ANY QUESTIONS OR NEED HELP, PLEASE CALL ME.

_____ NAME

_____ PHONE #

PLEASE HAVE THE RESULTS OF THIS EXAM WRITTEN ON THE BACK OF THIS FORM AND RETURN THE FORM TO YOUR CHILD'S TEACHER

HEALTHY CHILDREN LEARN BETTER

FINDINGS: SCHOOL SCREENING TEST DATE: _____

I. Results of 1st School Hearing Screen:
Date: _____
Calibration: ISO

HEARING LOSS STATUS

Frequency	Left Ear	Right Ear
1000		
2000		
4000		

II. Results of 2nd School Hearing Screen:
Date: _____
Calibration: ISO

HEARING LOSS STATUS

Frequency	Left Ear	Right Ear
1000		
2000		
4000		

Comments: _____

****

REPORT OF HEARING EXAMINATION: Date: _____

Diagnosis or explanation: _____

Plan of treatment: _____

Recommendations for School: _____

Physicians's Printed Name: _____

or

Audiologist's Printed Name: _____

Signature: _____

Office Phone: _____ Date: _____

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PRESCHOOL HEALTH APPRAISAL PROJECT

PARENT REPORT

IN REVIEWING YOUR CHILD'S CONFIDENTIAL PARENT QUESTIONNAIRE, YOU INDICATED THAT _____:

_____ OFTEN STARTS FIGHTS WITH OTHERS

_____ HAS TROUBLE SLEEPING/BAD DREAMS

_____ IS VERY SHY/CRIES A LOT/MOODY

_____ HAS A "BAD TEMPER"/TANTRUMS

_____ IS OFTEN AFRAID OF THINGS/INSECURE

_____ IS VERY DISOBEDIENT

_____ ALWAYS CRIES WHEN I LEAVE

_____ OTHER_____

IF YOUR CHILD IS STILL HAVING THIS PROBLEM AND YOU WOULD LIKE TO HAVE HELP, CALL:

_____ _____
NAME PHONE #

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PRESCHOOL HEALTH APPRAISAL PROJECT

PARENT ADVISORY REFERRAL

DEAR PARENT:

YOUR CHILD, _____, RECENTLY HAD A HEALTH SCREENING AS A SERVICE OF THE PRESCHOOL HEALTH APPRAISAL PROJECT (PSHAP). YOUR CHILD HAS BEEN REFERRED FOR THE FOLLOWING MEDICAL/HEALTH PROBLEM(S):

FINDINGS: _____

_____

_____

BASED ON THESE FINDINGS, IT APPEARS ADVISABLE THAT YOUR CHILD HAVE A MORE THOROUGH EXAMINATION BY:

PHYSICIAN OTHER _____

PLEASE CALL ME IF YOU HAVE ANY QUESTIONS OR NEED HELP.

_____ _____

NAME PHONE #

REPORT OF EXAMINATION

DIAGNOSIS OR EXPLANATION: _____

_____

TREATMENT NEEDED: _____

_____

RECOMMENDATION FOR SCHOOL: _____

_____

_____ _____

PHYSICIAN'S NAME PHONE #

PLEASE RETURN THE RESULTS OF THIS EXAM TO YOUR CHILD'S TEACHER

HEALTHY CHILDREN LEARN BETTER

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PRESCHOOL HEALTH APPRAISAL PROJECT

BLOOD PRESSURE SCREENING REFERRAL

DEAR PARENT:

WE HAVE COMPLETED THE BLOOD PRESSURE SCREENING ON YOUR CHILD, _____, PROVIDED AS PART OF THE PRESCHOOL HEALTH APPRAISAL PROJECT (PSHAP). IT IS RECOMMENDED THAT A STUDENT CHECK WITH HIS DOCTOR FOR FURTHER EXAMINATION WHEN HIS/HER BLOOD PRESSURE IS ELEVATED AT THREE DIFFERENT TIMES. YOUR CHILD HAD THE FOLLOWING ELEVATED READINGS:

DATE OF SCREENING	BLOOD PRESSURE READING	ARM USED
1. _____	_____	RT._____ LT._____
2. _____	_____	RT._____ LT._____
3. _____	_____	RT._____ LT._____

PLEASE ASK YOUR DOCTOR TO COMPLETE THE FORM BELOW AND RETURN IT TO YOUR CHILD'S TEACHER.

PHYSICIAN'S REPORT OF BLOOD PRESSURE EXAMINATION

STUDENT'S NAME_____

EXAMINATION FINDINGS:

RECOMMENDATIONS AND/OR TREATMENT:

PHYSICIAN'S
PRINTED NAME: _____
SIGNATURE: _____
OFFICE PHONE:_____DATE:_____

PLEASE HAVE THE RESULTS OF THE REFERRAL WRITTEN ON THIS FORM, AND RETURN THE INFORMATION TO YOUR CHILD'S TEACHER

THANK YOU FOR KEEPING YOUR CHILD HEALTHY
HEALTHY CHILDREN LEARN BETTER

PARENT HOME CARE INFORMATION

DURING YOUR CHILD'S HEALTH SCREENING, WE FOUND THAT _____ HAS A RED, **SORE THROAT**. HERE ARE SOME THINGS YOU CAN DO AT HOME TO HELP YOUR CHILD FEEL BETTER.

- **HAVE YOUR CHILD DRINK AT LEAST 8 GLASSES OF CLEAR LIQUIDS LIKE FRUIT JUICES AND WATER. SIPPING WARM BROTH CAN ALSO SOOTHE THE THROAT.**
- **YOU MAY USE AN ASPIRIN SUBSTITUTE SUCH AS TYLENOL, TEMPRA OR LIQUIPRIN FOR THE RELIEF OF HEADACHE, SORE THROAT OR FEVER. FOLLOW THE DIRECTIONS ON THE MEDICINE.**
- **DO NOT USE ASPIRIN.**
- **SUCKING ON SUGAR-FREE HARD CANDY CAN HELP KEEP THE THROAT MOIST.**
- **SEE YOUR DOCTOR IF YOUR CHILD DOES NOT SEEM BETTER IN A FEW DAYS OR IF THE FEVER INCREASES.**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000142 3/92

PARENT HOME CARE INFORMATION

DURING YOUR CHILD'S HEALTH SCREENING, WE DISCOVERED THAT _____ HAS A RASH WHICH WE BELIEVE IS **IMPETIGO**. THE INSTRUCTIONS BELOW MAY HELP YOU HANDLE THIS HEALTH PROBLEM AT HOME.

- **IMPETIGO IS A SKIN INFECTION CAUSED BY A BACTERIA WHICH OFTEN FOLLOWS SORES, INSECT BITES, AND OTHER SKIN RASHES.**
- **IMPETIGO CAN BE TREATED WITH A MEDICINE SUCH AS BACITRACIN OR POLYSPORIN WHICH YOU CAN BUY WITHOUT A PRESCRIPTION. READ AND FOLLOW THE DIRECTIONS ON THE MEDICINE.**
- **BEFORE YOU PUT ON THE MEDICINE, REMOVE THE CRUSTS OF THE RASH BY SOAKING ALL SORES IN WARM WATER FOR 5 MINUTES AND THEN WASHING THEM WITH A WASH CLOTH, WARM WATER, AND AN ANTISEPTIC SOAP LIKE DIAL OR SAFEGUARD.**
- **IF YOUR CHILD HAS IMPETIGO IN THE NOSE, IT MAY BE NECESSARY TO PUT THE OINTMENT ON A COTTON SWAB AND APPLY IT TO THE SORES IN THE NOSE.**
- **WASH YOUR HANDS AFTER TOUCHING THE SORES.**
- **KEEP YOUR CHILD'S TOWEL AND WASHCLOTH SEPARATE. WASH HIS/HER WASHCLOTHS, TOWELS, BEDDING, AND CLOTHING WITH HOT WATER AND BLEACH. DRY WITH HIGH HEAT OR IN THE SUN.**
- **KEEP YOUR CHILD'S FINGERNAILS CLEAN AND CUT SHORT TO KEEP HIM/HER FROM SPREADING THE RASH.**
- **YOUR CHILD CAN RETURN TO SCHOOL AFTER TREATMENT IS STARTED.**
- **IF THE RASH DOES NOT GET BETTER, TAKE YOUR CHILD TO THE DOCTOR.**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000150 03/92

PARENT REPORT

AS PART OF THE HEALTH SCREENING, YOUR CHILD, _____ _____, WAS WEIGHED AND MEASURED. OUR MEASUREMENTS SHOW THAT HE/SHE IS SHORTER THAN MOST CHILDREN HIS/HER AGE. THIS MAY NOT BE A PROBLEM IF OTHERS IN YOUR FAMILY ARE SHORT. HOWEVER, THIS IS SOMETHING THAT YOU SHOULD BE AWARE OF AND WILL WANT TO MONITOR AT HOME TO BE SURE THAT YOUR CHILD IS GROWING AND DEVELOPING NORMALLY. CHILDREN DO NOT ALWAYS GROW AT A STEADY RATE, AND THIS MAY BE A NORMAL PERIOD OF SLOW GROWTH FOR YOUR CHILD. PLEASE TELL YOUR CHILD'S DOCTOR OF OUR FINDINGS AT YOUR NEXT VISIT TO BE SURE THAT THIS IS NOT A PROBLEM.

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML 1000151 03/92

PARENT HOME CARE INFORMATION

AS PART OF THE SCHOOL HEALTH SCREENING, YOUR CHILD'S HEARING WAS TESTED. WE FOUND THAT _____ HAS A POSSIBLE PROBLEM. THE PROBLEM MAY BE DUE TO EARWAX WHICH IS BLOCKING THE EAR CANAL.

EAR WAX IS HEALTHY IN NORMAL AMOUNTS BUT CAN BLOCK THE EAR CANAL IF IT BUILDS UP. THIS CAN PREVENT YOUR CHILD FROM HEARING WELL.

EARWAX CAN BE REMOVED BY YOUR DOCTOR, OR BY USING AN OVER THE COUNTER PRODUCT TO SOFTEN THE EARWAX SO IT WILL NO LONGER BLOCK THE CANAL. HERE ARE SOME HEALTH TIPS TO HELP YOU:

- **DO NOT USE COTTON SWABS (Q-TIPS) TO CLEAN YOUR CHILD'S EARS SINCE THIS PUSHES WAX DOWN INTO THE EAR. USING A WASH CLOTH AT BATH TIME IS ENOUGH TO CLEAN THE EARS.**
- **DO NOT TRY TO PULL WAX OR ANY OTHER OBJECT OUT OF THE EAR BY STICKING ANYTHING IN THE EAR. THE EAR IS VERY SENSITIVE AND CAN BE EASILY DAMAGED. SEE YOUR DOCTOR IF YOUR CHILD HAS AN OBJECT THAT NEEDS TO BE REMOVED.**
- **IF YOU ARE SURE THAT YOUR CHILD DOES NOT HAVE A HOLE IN THE EARDRUM FROM A PREVIOUS INFECTION, YOU CAN TRY USING AN OVER THE COUNTER EARWAX SOFTENING AGENT, SUCH AS AURO EARDROPS. YOU CAN GET THIS AT THE DRUG STORE AND USE IT ACCORDING TO THE DIRECTIONS.**
- **IF THIS DOES NOT HELP YOUR CHILD HEAR BETTER, YOU WILL NEED TO SEE YOUR FAMILY DOCTOR.**
- **WE WILL RETEST YOUR CHILD'S HEARING IN A FEW WEEKS TO SEE IF THE PROBLEM HAS BEEN CORRECTED.**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental
Bureau of Maternal and Child Health
Division of Children's Health

ML#000145 03/92

PARENT HOME CARE INFORMATION

DURING YOUR CHILD'S HEALTH SCREENING, WE FOUND THAT _____ HAS A **COLD**. HERE ARE SOME THINGS THAT YOU CAN DO AT HOME TO HELP YOUR CHILD FEEL BETTER.

- **HAVE YOUR CHILD DRINK AT LEAST 8 GLASSES EACH DAY OF LIQUIDS LIKE FRUIT JUICES AND WATER. WARM BROTH IS ALSO GOOD BECAUSE IT MAY HELP THIN THE THICK MUCOUS. YOU MAY WANT TO LIMIT THE AMOUNT OF MILK YOUR CHILD DRINKS DURING THIS TIME BECAUSE IT SOMETIMES CAUSES MUCOUS TO THICKEN. DO NOT BE CONCERNED IF YOUR CHILD DOES NOT FEEL LIKE EATING. LIQUIDS ARE MORE IMPORTANT WHEN YOUR CHILD IS SICK.**

- **SALT WATER NOSE DROPS MAY BE HELPFUL FOR A STUFFY NOSE, ESPECIALLY BEFORE MEALS OR AT BEDTIME. SALT WATER DROPS ARE MADE BY MIXING 1/4 TEASPOON OF SALT IN 1/2 CUP OF WARM WATER. USE TWO OR THREE DROPS IN EACH SIDE OF THE NOSE.**

- **YOU MAY USE AN ASPIRIN SUBSTITUTE SUCH AS TYLENOL, TEMPRA OR LIQUIPRIN FOR THE RELIEF OF HEADACHE, SORE THROAT OR FEVER. FOLLOW THE DIRECTIONS ON THE MEDICINE.**

- **DO NOT USE ASPIRIN.**

- **KEEP YOUR CHILD HOME FROM SCHOOL IF HE/SHE HAS FEVER (101 DEGREES OR HIGHER).**

- **SEE YOUR DOCTOR IF YOUR CHILD DOES NOT GET BETTER IN A FEW DAYS OR THE FEVER GOES HIGHER.**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000143 03/92

PARENT HOME CARE INFORMATION

CLEAN & NEAT IS HARD TO BEAT!

HEALTHY CHILDREN LEARN HOW TO CARE FOR THEIR BODIES.

YOU CAN HELP BY TEACHING YOUR KINDERGARTEN CHILD TO:

- **WASH HANDS BEFORE EATING**
- **WASH HANDS AFTER USING THE BATHROOM**
- **TAKE A BATH OR SHOWER EVERY DAY**
- **KEEP FINGERNAILS & TOENAILS TRIMMED AND CLEAN**
- **WASH HAIR AT LEAST ONCE A WEEK**
- **CHANGE UNDERCLOTHES EVERY DAY**
- **WEAR ONLY ONE LAYER OF UNDERCLOTHES**
- **BRUSH TEETH AFTER EVERY MEAL**
- **FLUSH THE TOILET EACH TIME THEY USE IT**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal & Child Health
Division of Children's Health

ML#000144 03/92

PARENT HOME CARE INFORMATION

DURING YOUR CHILD'S HEALTH SCREENING, WE DISCOVERED THAT _____ HAS A RASH WHICH WE BELIEVE IS **ECZEMA**. THE FOLLOWING INSTRUCTIONS MAY HELP YOU HANDLE THIS HEALTH PROBLEM AT HOME.

- **ECZEMA IS USUALLY A RESULT OF DRY SKIN. IT IS NOT CONTAGIOUS. IT CAN BECOME INFECTED IF NOT TREATED.**
- **KEEP YOUR CHILD'S FINGERNAILS CLEAN AND CUT SHORT TO KEEP HIM/HER FROM SPREADING THE RASH OR CAUSING INFECTION.**
- **COTTON CLOTHING IS BEST. EXPOSURE TO WOOL, FLANNEL, SILK OR FEATHERS CAN IRRITATE THE SKIN.**
- **USE A MILD, MOISTURIZING SOAP AND WATER TO KEEP THE AREA CLEAN, BUT DO NOT OVERWASH. TOO MUCH SOAP CAN IRRITATE THE SKIN.**
- **AVOID LOTIONS, OILS OR GREASY OINTMENTS.**
- **WASH AND RINSE NEW LINENS AND CLOTHING BEFORE FIRST USE TO REMOVE ANY CHEMICAL THAT MIGHT HAVE BEEN USED IN MAKING THEM. USE A MILD DETERGENT.**
- **IF THE RASH DOES NOT GET BETTER, TAKE YOUR CHILD TO THE DOCTOR.**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING <u>YOUR</u> CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000149 03/92

PARENT HOME CARE INFORMATION

DURING YOUR CHILD'S HEALTH SCREENING, WE FOUND THAT

_____ HAS A RASH WHICH WE BELIEVE IS **SCABIES**. SCABIES IS CAUSED BY TINY INSECTS CALLED MITES THAT BURROW UNDER THE SKIN, CAUSING A RASH TO APPEAR. SCABIES NEEDS A PRESCRIPTION MEDICINE TO CLEAR IT UP. **YOU WILL NEED TO TAKE YOUR CHILD TO THE DOCTOR**.

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML# 000153 03/92

PARENT HOME CARE INFORMATION

DURING YOUR CHILD'S HEALTH SCREENING, WE DISCOVERED THAT _____ HAS A RASH WHICH WE BELIEVE IS **RINGWORM**. THE INSTRUCTIONS BELOW MAY HELP YOU HANDLE THIS HEALTH PROBLEM AT HOME.

RINGWORM IS NOT A WORM, BUT AN INFECTION CAUSED BY A FUNGUS.

- **RINGWORM CAN BE TREATED WITH TINACTIN OR MICATIN, WHICH YOU CAN BUY WITHOUT A PRESCRIPTION. READ AND FOLLOW THE DIRECTIONS ON THE MEDICINE.**
- **DO NOT ALLOW YOUR CHILD TO LET OTHERS WEAR HIS/HER CLOTHES OR HATS UNLESS THEY ARE WASHED FIRST. DO NOT SHARE COMBS OR BRUSHES WITH YOUR CHILD OR WITH OTHER PEOPLE IN THE HOUSEHOLD.**
- **EXCEPT FOR A BATH, KEEP YOUR CHILD'S SKIN DRY, AS WET SKIN MAKES THE RASH WORSE.**
- **KEEP YOUR CHILD'S FINGERNAILS CLEAN AND CUT SHORT TO KEEP HIM/HER FROM SPREADING THE RASH.**
- **THE INFECTION IS NOT CONTAGIOUS AFTER TWO DAYS OF TREATMENT. YOUR CHILD CAN GO TO SCHOOL IF TREATMENT HAS BEGUN.**
- **RINGWORM CAN BE CAUGHT FROM A CAT OR DOG. IF YOU HAVE A PET, HAVE A VETERINARIAN CHECK YOUR ANIMAL FOR RINGWORM. YOU CAN USE THE OVER THE COUNTER MEDICINE YOU BOUGHT FROM THE DRUGGIST ON YOUR PET.**
- **IF THE RASH DOES NOT GET BETTER, OR SPREADS TO YOUR CHILD'S HEAD, TAKE YOUR CHILD TO THE DOCTOR.**

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000148 03/92

PARENT REPORT

AS PART OF THE HEALTH SCREENING, YOUR CHILD, _____ _____, WAS WEIGHED AND MEASURED. OUR MEASUREMENTS SHOW THAT FOR HIS/HER HEIGHT, HE/SHE IS OVERWEIGHT. WE ARE SENDING THESE PAMPHLETS, "THE OVERWEIGHT CHILD" AND "FEEDING YOUR GROWING CHILD: 6 TO 10 YEARS" TO YOU. THEY TELL YOU WAYS TO HELP YOUR CHILD EAT WELL BUT NOT GAIN A LOT OF WEIGHT.

IF YOU WOULD LIKE SOME HELP WITH HIS/HER DIET, YOU MAY WANT TO CONTACT YOUR FAMILY DOCTOR OR YOU CAN ASK TO SEE A NUTRITIONIST AT YOUR LOCAL HEALTH DEPARTMENT.

_____ _____

NAME PHONE #

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000152 03/92

PARENT REPORT

DURING YOUR CHILD'S HEALTH SCREENING, WE FOUND _____

_____ HAS **HEAD LICE**. THIS IS A HEALTH PROBLEM THAT CAN USUALLY BE TREATED AT HOME. WE ARE SENDING YOU A PAMPHLET, "HEAD LICE ALERT," WHICH SHOULD HELP YOU HANDLE THIS PROBLEM.

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000147 03/92

PARENT HOME CARE INFORMATION

AS PART OF THE SCHOOL HEALTH SCREENING SERVICES, WE CHECKED YOUR CHILD'S TEETH. THE NURSE FOUND THAT YOUR CHILD NEEDS SOME HELP IN KEEPING HIS/HER TEETH CLEAN & HEALTHY. PLEASE HELP YOUR CHILD BY:

- **TEACHING PROPER TEETH BRUSHING AND FLOSSING**
- **USING FLUORIDE IN WATER, TOOTHPASTE & MOUTH RINSE**
- **PROVIDING HEALTHY MEALS AND SNACKS**
- **SEEING A DENTIST FOR REGULAR CHECK-UPS**
- **HAVING DENTAL SEALANTS PLACED AS NEEDED**

WE ARE SENDING YOU A PAMPHLET, **"THE GROWTH AND CARE OF YOUR CHILD'S TEETH,"** WHICH MAY HELP YOU PREVENT TOOTH DECAY.

HEALTHY CHILDREN LEARN BETTER

THANKS FOR KEEPING YOUR CHILD HEALTHY!

South Carolina Department of Health and Environmental Control
Bureau of Maternal and Child Health
Division of Children's Health

ML#000148 03/92

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

****

PRE-SCHOOL HEALTH APPRAISAL PROJECT

****

PSHAP SCHOOL RESPONSIBILITIES

1. Assure that participating school principals and other administrative staff are supportive of the project and willing to provide adequate facilities to accomplish all screening components.

2. Ensure classroom teacher support, cooperation, and assistance with outreach, logistical support, classroom health promotion activities, and referral completion efforts.

3. Ensure the collaboration and active participation of school health nurses in all stages of planning, implementing and conducting the appraisal, follow-up, and in-school case management activities.

4. Write cover letter on school letterhead to accompany the Confidential Parent Questionnaire. The letter should describe the cooperative project with the Department of Health; briefly describe the appraisal (which will include an unclothed physical exam accomplished by qualified health professionals); invite the parent to be present if they wish; and encourage them to take advantage of this special opportunity for a comprehensive physical exam at no cost to the participants. All enrolled five year old kindergarten students in participating schools are eligible to participate.

5. Collaborate in the development and implementation of community outreach activities to increase community awareness of the examination. Specific goals should be directed at encouraging student participation and enhancing compliance with follow-up recommendations when a potential problem is identified. Such initiatives should focus on the benefits of having healthy learners.

6. Provide classroom rosters of all enrolled kindergarten students, including date of birth, race, previous public school Early Child Development programs and the classroom teacher's name.

7. Accept and expedite all PSHAP referrals for the special services available in the participating school district (i.e. speech therapists, school psychologists, guidance counselors, nursing care, etc).

8. Assist the project nurse coordinator with referral follow-up activities to expedite parental contact via letters disseminated through the school. Every problem identified through screening will be referred for parental action, and all channels of communication with parents should be used to facilitate referral completion. School staff should assist the PSHAP nurse coordinator, who will assume responsibility for case management follow-up actions to assist parents in obtaining needed evaluation and care.

9. Ensure that health information related to appraisal findings is handled confidentially, protecting the student's right to privacy. Access to confidential health information should be limited to the school health nurse, and records containing confidential health information maintained in accordance with Guidelines for "School Health Records."

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

****
PRE-SCHOOL HEALTH APPRAISAL PROJECT
****

PSHAP HEALTH DISTRICT RESPONSIBILITIES

1. Establish and maintain a liaison relationship with each school district's administrative staff.

2. Assume the responsibility for planning and implementing the project cooperatively with each school district and each school in accordance with DHEC Child Health Standards and the PSHAP project requirements.

3. Commit qualified nursing staff for timely completion of the appraisals as mutually agreed on by the health district and the local school district.

4. Provide all project forms for each school to distribute to kindergarten parents (Confidential Parent Questionnaire).

5. Provide all equipment and supplies used in completing the examinations.

6. Inform all parents (through school district distribution) of the results of their child's appraisal.

7. Support the case-management follow-up activities in accordance with project requirements.

8. Compile a school district specific, aggregate summary report with all relevant findings from the project.

9. Provide relevant individual student/patient information to School Health Nurse for School Health Record data base.

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

****
PRE-SCHOOL HEALTH APPRAISAL PROJECT
****

PSHAP COORDINATOR RESPONSIBILITIES

1. Serve as primary contact and liaison with school principal, teachers and school nursing staff for planning and implementing the project.

2. Establish liaison with private and public referral resources to expedite referral follow-up process for problems identified and receive needed outcome data regarding findings.

3. Pre-view proposed school screening accommodations for acceptability, assuring that adequate space is available and appropriate for conducting health appraisals.

4. Provide classroom health awareness activity prior to scheduled screening.

5. Schedule and coordinate assigned DHEC Nursing staff and available School Nursing staff to assure that adequate qualified staff are on site to conduct the appraisals and re-screens as necessary.

6. Monitor each screening site to promote quality assurance and assure that Child Health Standards are being met by all providers and PSHAP forms are completed correctly.

7. Monitor all PSHAP records and maintain Log for each classroom to assure accurate documentation and account for individual child's status at any given time during the course of the screening.

8. Establish a method to identify EPSDT eligible children and file for screening reimbursement. Maintain a record of the number of children whose exam is reimbursable.

9. Review each record to ensure completion of all sections and initiate Referral Follow-up Forms for each referable condition identified.

10. Pursue each referral to completion of diagnosis for each referable condition identified as part of the PSHAP exam.

11. Provide originals of all Referral Follow-up Forms and completed logs documenting all findings and outcomes to Central Office no later than April 30, 1991.

12. Maintain communication and serve as primary contact with C.O. project coordinator.

7/90

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIORNMENTAL CONTROL

Pre-School Health Appraisal Project

CONFIDENTIAL Parent Questionnaire - Coordinator's Instructions

1. The school district will distribute the Confidential Parent Questionnaire to parents of all enrolled kindergarten students, along with a cover letter on school stationary explaining the project and encouraging them to allow their child to participate.

2. The project coordinator should request alphabetized classroom rosters from each school with the teacher's name, the student's name, date of birth, race and sex for all kindergarten classes. Request computerized Student Data Edit Screen with student's name, parent/guardian's name, home address, parent's place of employment, and home and work phone numbers for use in referral follow-up activities.

3. Transfer the names from each roster to a PSHAP log, listing the assigned individual project identification number for each student in the class. The ID numbers should be assigned sequentially by class. The log serves as the master list and is used for documentation of findings and for tracking purposes.

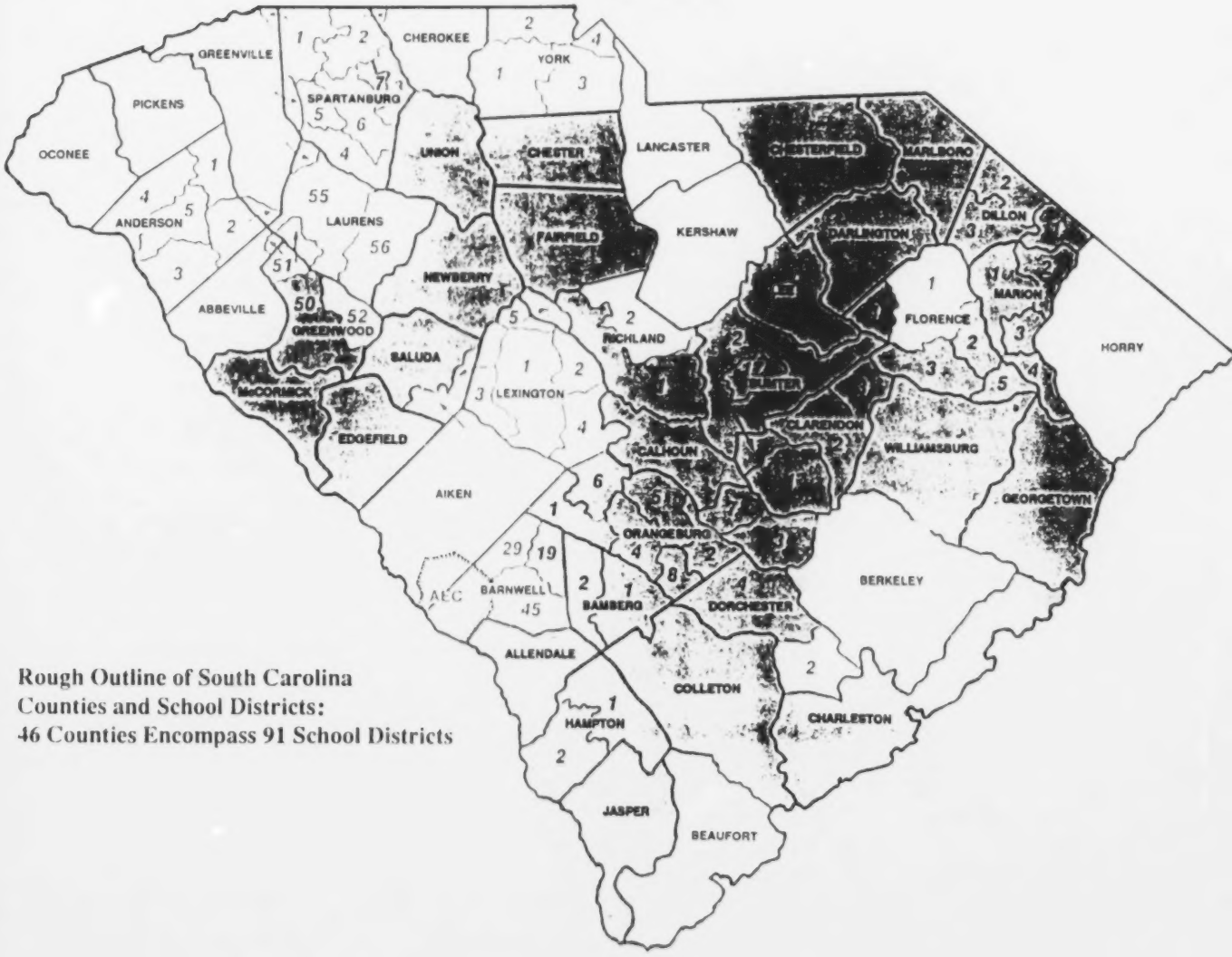
4. In the event that a form is lost and a duplicate form issued, the assigned project code number must be hand written on a blank survey form and provided to the parent on individual request. You may wish to provide each teacher with some blank forms to be used for this purpose.

5. The individual's project ID number must be hand copied by the examiner onto the **Screening Form** and the **Physical Exam Form** as the child begins that portion of the exam. As each form is completed, it is then stapled to the student's **Confidential Parent Questionnaire**, thus maintaining all components of each record together.

6. The Log must document all information required for the state report and include final status of referral outcomes. All referable conditions must be listed on the log. Each condition must be included on the log, and a **Referral Follow-up Form** (DHEC 739) sent for each condition identified.

APPENDIX II

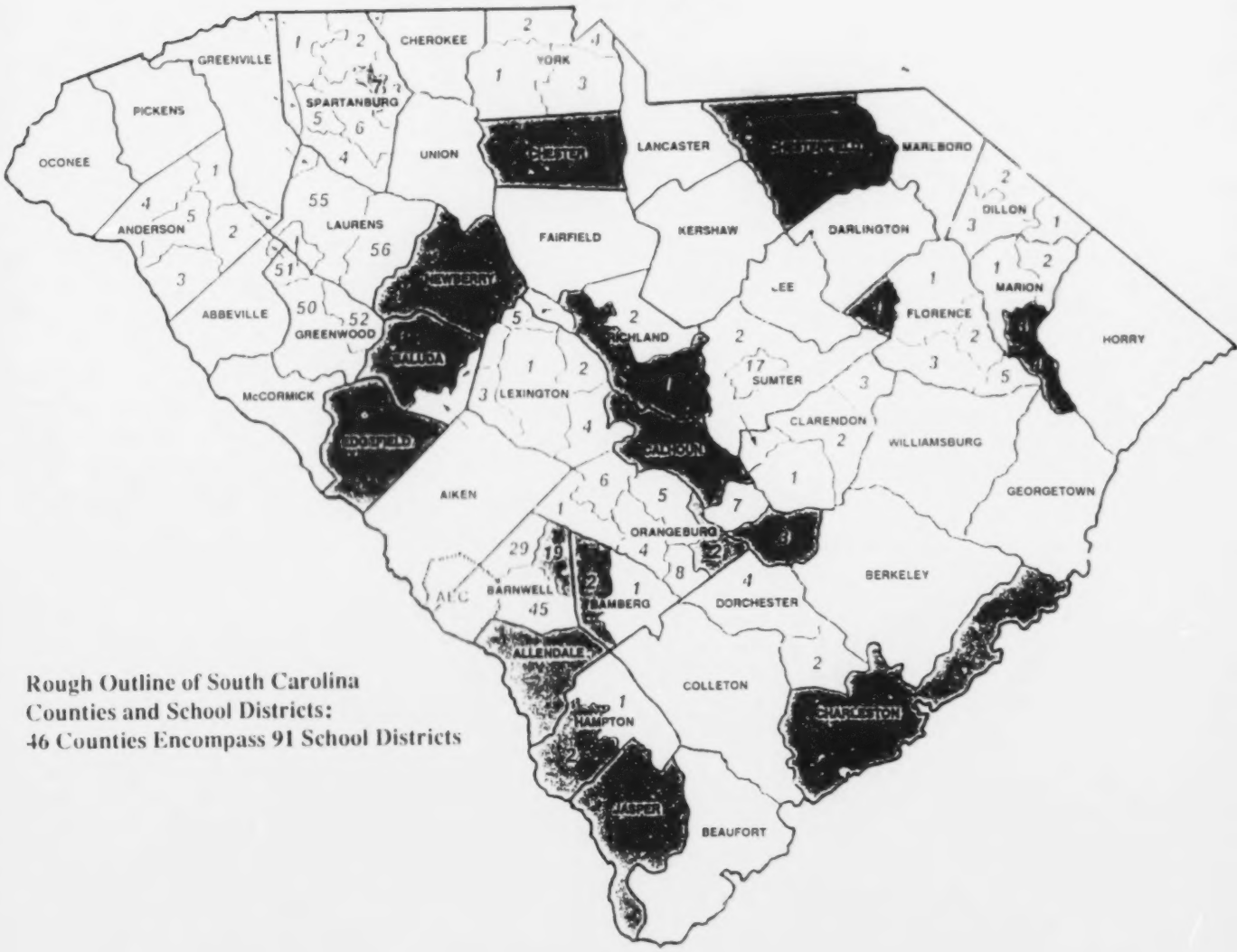
South Carolina School Districts Eligible For PSHAP
(>50% of Enrolled Students on Free/Reduced Lunch) N=50
Year 4, 1991-1992



Rough Outline of South Carolina
Counties and School Districts:
46 Counties Encompass 91 School Districts

BEST COPY AVAILABLE

Selected PSHAP Participating School Districts N=18
Year 4, 1991-1992



Rough Outline of South Carolina Counties and School Districts:
46 Counties Encompass 91 School Districts

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